DEPARTMENT OF WORKFORCE DEVELOPMENT
DIVISION OF ECONOMIC SUPPORT
ADMINISTRATOR'S MEMO SERIES

ACTION: 99-10 (AMENDED)

ISSUE DATE: 06/01/99
DISPOSAL DATE: Ongoing

RE: BADGERCARE
IMPLEMENTATION PLANS

To: County Department of Human Services Directors
County Department of Social Services Directors
County Economic Support Managers/Supervisors
Tribal Chairpersons/Human Services Facilitators
Tribal Economic Support Directors
W-2 Agency Directors

From: J. Jean Rogers /s/
Administrator

You recently received an Administrator's Memo on BadgerCare Implementation Plans (99-10). Attached to the Administrator's Memo was a new one-page BadgerCare Application Supplement form that will be used by local agencies to obtain additional information needed to determine BadgerCare eligibility. A minor change has been made to this form since the Administrator's Memo was distributed. The change does not affect the content of the form, but was located in a 'worker only' shaded area of the form.

Please replace the previous BadgerCare Application Supplement form with the corrected version attached to this cover memo. A supply of the correct version of the form will be mailed in late June to all local agencies.

ACTION SUMMARY STATEMENT: Replace this BadgerCare Application Supplement form (attached to this Administrators' Memo) with the form attached to the previously received Administrator's Memo.

REGIONAL OFFICE CONTACT: Area Administrator

Attachment

cc: Peggy L. Bartels, Division of Health Care Financing
John Chapin, Division of Public Health

STATE OF WISCONSIN
DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Economic Support

BadgerCare Application Supplement

Shaded Areas – Worker Only

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

Case Number	Case Name	Casehead SSN

Use this form when:

- Another family member you live with (child, spouse) is currently receiving Medicaid, Food Stamps, Child Care assistance or W-2 benefits and you would like to request BadgerCare.
- You are completing a review for Medicaid, Food Stamps, Child Care assistance or W-2 benefits.
- Your are applying for Medicaid/BadgerCare for yourself and your family.

A. General Information

(ACPA-BC)

Do you want to receive BadgerCare? ☐ Yes ☐ No

Is there anyone in your household who you don't want to receive BadgerCare? ☐ Yes ☐ No
If yes, please list their names and dates of birth below.

Name	Date of Birth
Name	Date of Birth

B. Employment Information (Fill out this section for each employed individual.)

(AFEI/AFAC)

First Employed Person Name

Employer Name and Address

What is your Employer's phone number? ( )

Do you have access to family medical insurance through this employer? ☐ Yes ☐ No

Second Employed Person Name

Employer Name and Address

What is your Employer's phone number? ( )

Do you have access to family medical insurance through this employer? ☐ Yes ☐ No

C. Medical Insurance Information

(AFMQ/AFMC/AFMI)

Does anyone in the household have health care coverage now or in the past three months? ☐ Yes ☐ No

Health Policy Company Name

Health Policy Number	Health Group Number

Who is Covered?

Name	Beginning	Name	Beginning
Name	Beginning	Name	Beginning

Shaded Areas – Worker Only

Does this policy meet the HIPAA standard plan requirements?	☐ Yes ☐ No

D. BadgerCare Premium Payer Information

(AGPI)

(We need this information if your family's income requires you to pay a BadgerCare Premium)

If you have to pay a premium, who would be the premium payer?	Name
What premium method would you prefer?	☐ Electronic Funds Transfer (EFT) ☐ Wage-withholding ☐ Direct Payment

I have been given a copy of the BadgerCare informational material. I understand that BadgerCare is not available to persons covered by health insurance and to persons whose employers offer access to a family health plan and pay 80% or more of the premium. I also understand that families with income greater than 150% of the Federal Poverty Level must pay a premium to receive BadgerCare. I certify that the information that I have provided on this form is accurate and complete to the best of my knowledge, and that I understand the BadgerCare eligibility requirements described above.

Primary Person Signature	Date Signed

Case Comments